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Being Female and Indigenous: Barriers to Reducing Bolivia's Maternal Mortality Rates Under Evo Morales

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BEING FEMALE AND INDIGENOUS: BARRIERS TO REDUCING BOLIVIA'S MATERNAL MORTALITY RATE UNDER EVO MORALES

By

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ABSTRACT

CHANNELL METTE COLE: Being Female and Indigenous: Barriers to Reducing Bolivia's Maternal Mortality Rate Under Evo Morales (Under the direction of Dr. Kate Centellas)

This thesis seeks to answer the question: What are the barriers to attempts to reduce Bolivia's maternal mortality rate under Evo Morales? While Morales' presidency began in 2006, the timeline is from 2004 to present to account for changes of due to his policy. Using activity theory and social capital theory, I argue that machismo and racism are two social factors that are barriers to efforts to reduce the maternal mortality rate. Machismo manifests itself uniquely in Bolivia, as I argue through a comparison to Paraguay. Machismo is also riddled with a history of anti-indigenous racism. I examine the Rockefeller Foundation's international aid in the 20th century and how foundations like this have impacted intercultural healthcare today. Resulting racism experienced in the past and present limit participation in intercultural healthcare initiatives to combat maternal mortality rates. I apply this theory to the UNPF Midwifery Program and the Family Community Intercultural Health Program proposed by Morales. Then, I find the correlation coefficient between gender statistics provided by the World Bank and maternal mortality rates. This adds to the argument that machismo is unique and thus impacts intercultural healthcare's efforts to intervene in maternal mortality rates. Such a complicated health issue requires a complex solution that addresses the social issues both causing the problem and impeding a solution. I propose that two of these social issues are machismo and racism, but there is room to explore what other social issues are influencing this issue and how solutions may address them.

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Introduction

Maternal mortality rates are a reflection of the overall well-being of a country's citizens as well as a reflection of the state of the healthcare system. In 2017, according to the World Bank database, there were 155 maternal deaths per every 100,000 live births. Globally, efforts have been taken in the past twenty years to increase access to public health in developed countries like the United States as well as resource-limited countries like Bolivia. Yet, maternal mortality is a complex health issue that takes more than simply pouring resources into the community. In contrast, increasing immunization does not take much more than providing vaccines and distributors. Yet, for maternal mortality rates, resources should be provided not for just the moment of birth but also prenatal and postnatal care as well as generally increasing the overall health of the community. This takes more resources, time, and money than what many resource-limited countries can provide. Per activity theory, even the presence of resources does not translate to the use of resources. This paper argues that the maternal mortality rate remains high in Bolivia despite efforts to combat it under Evo Morales, the previous president, because of the high prevalence of machismo and racism in Bolivia. While these may not be the only factors influencing the maternal mortality rates and the implementation of intercultural health care, these are the two studied for this research.

First, machismo is a term relevant for most Latin American countries but it manifests itself uniquely in Bolivia. The quantitative research compares Bolivia's machismo to that of Paraguay's to show this. While Paraguay and Bolivia are similar

countries with similar histories, Bolivia's maternal mortality is much higher than Paraguay's, and as I argue, this is because machismo plays more of a role in the everyday life of Bolivians through controlling social capital. The reason this impacts maternal mortality rates is that it diminishes maternal mortality to be a "woman's problem" instead of a problem for which the whole community takes responsibility. When combined with the racism that Indigenous people experience in Bolivia, there is double discrimination for indigenous women attempting to utilize these services. Even more, machismo impacts all aspects of life, not only maternal mortality rates - decreased spending on women's health care, less formal education especially for indigenous girls, and higher rates of femicide for indigenous women. This creates anti-indigenous sentiments in many doctors who are to be a part of the intercultural healthcare services used to combat the high maternal mortality rate. Moreover, machismo is what gives men social capital. Social capital theory is a framework applied to this research. For the sake of this research, it means that community participation and engagement are essential for the functioning of intercultural healthcare services in place to combat maternal mortality rates. If there is not community acceptance of intercultural health care services, it will not be utilized by the community as a whole, and thus be ineffective despite how effective it might be in theory.

In conjunction with the fact that this is considered a "woman's problem", men making the health decisions of their wives, sisters, and daughters means that there is little encouragement to partake in these intercultural healthcare services. In addition to this, racism is another factor that I argue keeps the efforts to combat maternal mortality rates from being effective. The history of efforts in intercultural healthcare that I exemplify

through the Rockefeller Foundation explains the communities' distrust of efforts now to implement intercultural health services. These sentiments make Indigenous Bolivians skeptical of efforts like the UNPF Midwifery Program and the Family Community Intercultural Health Program. Therefore, racism makes the implementation of intercultural health care complex because it discourages Indigenous Bolivians from feeling comfortable enough to utilize it. After all, machismo and racism are factors related to negative health outcomes.

Finally, while some statistics may indicate that the maternal mortality rates are getting better over time, these numbers are skewed to leave out how this is a problem still very much impacting indigenous communities. Like the statistics of the UNPF exemplify, when the rural-urban divide is not included in these numbers, the indigenous communities can continue to be disregarded because when combined, it appears that more women are using skilled birth attendants and that the maternal mortality rate is decreasing. It may be true of urban populations, but maternal mortality and usage of intercultural healthcare programs is still a relevant issue in rural Bolivia and for indigenous communities.

Overall, this research does not serve to say that intercultural health services are ineffective overall because they do have a good purpose and the presence of them is better than no presence at all. Yet, as I argue, presence does not mean a success. Once proposed, intercultural health services need to address more than the problem at hand. There needs to be education to promote agency and involvement in the healthcare process. It should address all aspects of life and all stages of life because where we live, work, and play is what most impacts our health outcomes. While having a skilled birth

attendant is a step in the right direction, it is not the only step to be taken nor the only goal to set out to achieve when it comes to combating maternal mortality rates. Even more, there needs to be a better acknowledgment of the divide between the proposal and implementation of these services. While a well-worded policy sounds nice, the real goal is to combat maternal mortality rates, and this requires adequate implementation and use of these services. As activity theory proposes, a complex issue, like maternal mortality rates, requires a complex solution that will also require complex implementation. For the scope of this research, machismo and racism are two social factors that complicate maternal mortality rates and their solutions and implementations. While this research explains why current efforts are not working, there is room for further research to suggest better ways to integrate biomedicine and traditional medicine and increase the use of intercultural health services overall and not just for maternal mortality rates.

I. Background

This chapter defines two important concepts – machismo and intercultural health – that will be used throughout this research. Machismo is the driving force behind maintaining high maternal mortality rates in Bolivia. Machismo is a unique version of sexism that plays a role at both the individual level and the national level in Bolivia. The first section of this chapter seeks to further define this term.

Then, intercultural health is a field of study that intertwines with machismo to give the foundation for the research. Intercultural health care is relevant in Bolivia because of their indigenous population which is identified to be over 60% (Berstein, 2017, p.231). Intercultural services are aimed at increasing access to modern medicine to indigenous peoples throughout the country usually through the use of implementing clinics, doctors, and health services in rural areas. As will be discussed in another chapter of this research, these are the kinds of methods in place in Bolivia to combat high maternal mortality rates.

Machismo

Bolivia, as well as many Latin American countries, has a long history of machismo that still plays a role in daily life. The Merriam-Webster dictionary defines machismo as "a strong sense of masculine pride" or "exaggerated masculinity" (Merriam-Webster, n.d.). Scholars seem to agree with this definition as it was defined by anthropologists in 1987 as "a masculine display complex involving culturally sanctioned

demonstrations of hypermasculinity both in the sense of erotic and physical aggressiveness" (Mosher, 1991, p.227).

Something to emphasize, though, is the mention of physical aggressiveness. Machismo has been used to justify intimate partner violence and rape in Latin America even to this day. Davila's study, "The Impact of Machismo on Women's Health and Security in Peru and How the State Fails Women" (2019) analyzes why despite the presence of legislation surrounding gender-based violence in Peru, the prevalence of these crimes has not diminished. She concludes that the legislation remains willingly unenforced. This is evidence of how the culture of machismo impacts the health and security of women living in Latin America because "the lack of enforcement of the law in Peru surrounding femicide and other forms of gender-based violence is strongly linked to gender inequality in the country" (Davila, 2019, p.34). The policy requires implementation, and if the very people required to implement this kind of policy also have the mindset that caused it to come about, their likelihood of enforcing it is low. There are services available to combat maternal mortality rates yet implementation of these services is the issue, and social factors such as machismo are barriers to implementation.

Although indigeneity does not always mean rurality or vice versa, for simplicity, this paper assumes a correlation between the two. In 2020, 69.3% of Bolivia's overall population is considered to be urban, according to the World-o-Meter. First of all, even though that is more than half of Bolivia's population does not live rurally, 30% of the population does live this way, and this paper hypothesizes that the maternal mortality rate is partially skewed by this 30%. In addition, it is estimated that over 60% of Bolivia's

population identifies as indigenous (Berstein, 2017, p.231). This means that indigenous does not always mean rural and that there is a significant portion of self-identified indigenous people living in urban cities in Bolivia. So, we can assume rural means indigenous, but not the other way around because we know based on these statistics that indigenous people are living in urban cities. Rural indigenous women may lack adequate access to services, but what are the circumstances of indigenous women living in urban cities? Surely, they have access to services yet seem to underutilize them, so what are the structural barriers to Bolivian women's safety and health whether indigenous or not, living in the city or not?

Intercultural Health

Intercultural healthcare is the integration of a community network made up of local communities, traditional health, and biomedical staff to offer a culturally sensitive and holistic health service for indigenous people (Torri and Hollenberg, 2013, pp.216-229). The effectiveness of intercultural healthcare practices crosses over with social capital theory. Intercultural health care allows for indigenous people's agency in a healthcare setting. When traditional medicine can be integrated into modern medicine, there is more agency and therefore community acceptance.

Intercultural healthcare is a relevant field of study in this case because Bolivia's indigenous population is well over 60%, and there are 36 recognized indigenous groups within the country (Bernstein, 2017, pp.231-238). Although intercultural healthcare is assumed to be the integration of biomedicine and traditional healthcare, there are debates on the equality of the integration. Some studies suggest that intercultural healthcare

heavily leans more toward encouraging biomedicine, or Western, healthcare through the use of traditional medicine as encouragement (Brandby, 1999, pp.287-301). For example, a woman will be encouraged to give birth within a hospital, but they will allow for her to give birth alone, only receiving assistance from doctors and nurses after birth. This allows for her to receive biomedicine without completely disregarding her cultural beliefs, and this acceptance of others' culture decreases maternal mortality rates because an increase in hospital births leads to a decrease in maternal mortality, according to Kuberska's study (2016, pp.61-81). Yet, this policy makes the woman come to the hospital instead of bringing services to her.

Bolivia not only has a high indigenous population making indigenous women a significant portion of those experiencing maternal complications, but also, indigenous peoples in Bolivia have the worst sociodemographic indicators and experience the largest inequalities in terms of access to social services (Torri and Hollenberg, 2013, pp.216-229). While looking into machismo impacting women's overall maternal mortality rate, there is not just one kind of woman within a country or even within a city. Not only does indigeneity impact the people of Bolivia but also socio-economic factors barring them from adequate healthcare. Social determinants such as location (rural versus urban) and socioeconomic status between women must also play a role in determining women's healthcare.

There is a correlation between low income and poor health conditions with satisfaction in healthcare (Ouladi et. al, 2012, p.186). Health outcomes are determined by social factors and those factors, in turn, impact how we experience healthcare. In a poor state, poverty, poor education, and shortage of medical staff put healthcare at a

disadvantage for many people (Lowenberg, 2010, pp.1680-1682). The state of the Bolivian health care system plays a part in determining health outcomes for indigenous Bolivian women because according to the World Health Organization, "higher income countries devote a greater share of their income to health than do low income countries" (Global Spending on Health: A World in Transition, 2019). While financing intercultural health care is beyond the scope of this research, it is worth noting that Bolivia's health expenditure is about 12% of their overall governmental expenditure (Bolivia (The Plurinational State of) Key Indicators, n.d.). In 2019, Evo Morales proposed the Unified Health System that aimed to increase access to healthcare by promising to cover almost 6 million uninsured Bolivians. Yet, doctors criticized it saying they needed $1 billion instead of the $200 million they received to implement this (Allbery, 2020). While the scope of this research focuses on social determinants of health, financing health is also a factor that may be a barrier for implementation of services in Bolivia.

Nevertheless, even within a poor state, there is inequality to an even greater degree. Those at a lower socioeconomic level are more likely to have diminished health conditions because of social determinants like machismo and racism which then correlates to dissatisfaction in the healthcare setting. This makes these same people not want to turn to hospitals, doctors, and nurses due to poor experiences which further exacerbates their health problems which then increases their dissatisfaction in the healthcare setting. It goes in circles.

Additionally, the history of machismo and racism in Bolivia and most of Latin America is intermingled. This is highlighted in Bolivia's history of intercultural healthcare. Historically, problems such as illegal abortion, infant mortality, prostitution,

and sexually transmitted infections were deemed women's problems although men almost always plaid a role, for example, in the spread of sexually transmitted infections (Zulawski, 2007, p.147). Even more, these problems seemed to be blamed on "Indian-ness" and did not apply to all classes of Bolivian women. Women were and are blamed for the health of their children even when doctors are also at fault for "misdiagnosing children's illnesses and being inadequately trained in pediatrics", and she argues that "the fact that a child's death would not reflect as badly on a doctor as an adult's, was...a tacit acknowledgment of the frequency of infant mortality" (Zulawski, 2007, p127.). In another example, in 1952, the Department of Biostatistics' Director, Hubert Navarro, issued a report to Health Minister Julio Manuel Aramayo concerning the high infant and maternal mortality rates "[targeting] indigenous mothers that put their families and the nation at risk with their poor nutrition, deplorable hygiene, and use of 'ignorant, dirty and superstitious' midwives whose 'dangerous practices' created 'bad birth conditions'" (Pacino, 2015, p.62). Entangled in Bolivia's history and now the present is the belief that women are to blame for their own poor health outcomes especially indigenous women for the incorrect ideologies and practices. Instead of analyzing the conditions which cause poor health outcomes for these women, they become the scapegoat.

I argue the same is the case for maternal health; women are given the sole responsibility of maternal healthcare even when doctors misdiagnose and are inadequately trained. Intercultural health, when done incorrectly, has a politics of blame on indigenous people. Zulawski (2007), in her chapter on women and public health, concludes that:

> "Consciously or not, this attack by doctors on Andean women may have been linked to their ongoing efforts to establish their medical superiority. Doctors blamed Indian women for their children's death, yet the doctors themselves were far from able to save their children's lives from the infectious diseases that decimated the population every year." (p.155)

With histories of machismo and racism, the implementation of intercultural health services can be at times misguided. Maternal mortality rates are not the sole responsibility and cause of the women involved yet most programs in place only are aimed towards the women and specifically the women that the community seems to blame - indigenous women. This fact combined with what we know about social capital theory can provide insight into the ineffectiveness of programs in place to combat maternal mortality rates in Bolivia. The very history of racism and machismo makes it nearly impossible for indigenous women to confidently participate in these programs. The mere fact that these programs are mainly aimed at women adds to this fact because it becomes another "women's problem" like that of sexually transmitted infections making the community's response to them not that of encouragement to participate but of blame and shame for "not fulfilling their biological destiny and civic duty as mothers" (Zulawski, 2007, p.119).

Overall, intercultural health means, if done correctly, the incorporation of both aspects of medicine, modern and traditional, to give recipients agency because social factors influence the use of intercultural reproductive services by indigenous women. Although not the only reason machismo is rampant in Bolivia, the high presence of indigenous peoples in the country plays a role in machismo because they are underserved

in the implementation of intercultural health care. Indigenous women may skew significantly the statistics of maternal mortality in Bolivia because they are less likely to utilize the services created for them - intercultural healthcare. Although intercultural health implies a blending of the two systems, as I have found that it leans more toward the use of Western medicine in which indigenous practices are mixed as a way to motivate the use of Western medicine (Brandby, 1999, pp.287-301). Therefore, studying where Western medicine meets with traditional medicine for these women is important for garnering their participation and enthusiasm for using these programs. If they do not feel their needs are being met, they will not use the programs deeming the programs ineffective.

II. Qualitative Analysis

I analyze the ineffectiveness of efforts to combat maternal mortality rates in Bolivia. I first analyze non-governmental organizations' approaches to intercultural healthcare through a historical analysis of the Rockefeller Foundation's campaigns in Bolivia. Then, I apply what we learn through the Rockefeller Foundation to the current efforts of the United Nations Population Fund's Midwifery Program. Although many current non-governmental organizations are working in Bolivia, this one stands to represent them all because as I found through preliminary research, although their approaches may be different, their results are the same which are, as I analyze in the Midwifery program, ineffective. Then, I analyze governmental efforts to combat maternal mortality rates through Evo Morales's presidency (2006-2019) which serves as the reasoning for the time range. I begin the study in 2004 to account for the intercultural healthcare efforts before Evo Morales. Although his efforts may be somewhat effective applied over a long period, I analyze why for the current period, they have been ineffective.

Theoretical Framework

The theoretical framework for this research is based on two things: activity theory and social capital theory. Although I will further define the two terms, this section seeks to apply these theories to the efforts to implement intercultural health services to combat maternal mortality rates. Activity theory integrates "the conceptual separations between

levels of policy, management, and clinical care" therefore addressing the divide in policy and the complexity of implementation (Greig et. al, 2012, p.305). Social capital theory is defined as "any aspect of social structure that creates value and facilitates the actions of the individuals within that social structure" (Akdere, 2005, p.1). In other words, widespread participation garners more widespread participation which can be due to valuing the actions of a community or valuing the opinions of individuals. The agency of individuals is tied up in the agency of the community as a whole, according to this theory. These two theories work together in establishing that the complexity of the problem of maternal mortality requires a complex solution. While activity theory suggests there is a divide between policy and implementation, social capital theory suggests a lack of garnering social capital of a community attributes to the problem of implementation. Moreover, this study suggests that machismo and racism are the factors blocking the social capital garnering and therefore proper implementation.

Activity Theory

Greig et. al proposes in "Addressing Complex Healthcare Problems in Diverse Settings: Insights from Activity Theory" (2012) activity theory to contrast the knowledge transfer theory. Knowledge transfer theory suggests that "best practice solutions to complex problems can be identified and rolled out across organizations, [and] when the designated best practice is not implemented, this is interpreted as a local - particularly management - failure" (p.305). This places the blame, not on the proposing institution or policy but the community. To apply this, the problem in current efforts to diminish maternal mortality rates in Bolivia blames the local communities in which they are trying to implement intercultural health services instead of looking internally at the services and

their inadequacies in solution-finding. Activity theory, on the other hand, focuses on "objects of activity" and "sees new practice as emerging from contradiction and understands knowledge and practice as fundamentally entwined" (Greig et. al, 2012, p.305).

Activity theory combines the disciplines of medical sociology and health policy analysis which "provides, on the one-hand a cutting-edge and thought-provoking basis for the analysis of contemporary health reforms, and on the other hand, enables the development and elaboration of theory" (Currie et. al, 2012, p.273). In other words, solutions to complex issues are complex in their formation and implementation.

Maternal mortality is a complex health issue not only in Bolivia but more generally because it is a problem that is exacerbated by other complex social issues like poverty, racism, machismo, etc. Even more, it is nine months of pregnancy, the actual birthing process, and the period of postpartum health. The complexity also lies in the time it takes to address, and a complex issue will require a complex solution. Frambach et. al apply this theory in "Using Activity Theory to Study Cultural Complexity in Medical Education" (2016) and suggest that activity theory can "serve as an organizing principle to grasp cultural complexity" (p.190). This study explains the need for continued research on cultural effects and medical education. While they include that activity theory "is not a shortcut to capture cultural complexity", this research leaves room to explore the connection between the complex issue at hand and the proposed solutions lacking in implementation because of the complexity of the issue (Frambach et. al, 2016, p.190).

In the implementation of this theory, Casimiro et. al in "Enhancing Patient-Engaged Teamwork in Healthcare: An Observational Study" (2015) studies teamwork in

acute rural settings through analyzing the relationship between providers and patients and their exchanging of information. Their observations indicate the necessity of “valuing the perspectives of others, developing relational competence and resilience, employing reflective learning and shared decision-making skills, and incorporating principles of change theory for both individuals and systems" (Casimiro et. al, 2015, p.55). These findings support activity theory because we can imagine the complexity of implementing, for example, valuing the perspectives of others.

The issue of the persistence of maternal mortality rates in Bolivia can be attributed to a multitude of factors, and while current initiatives attempt to address these issues, there also seems to be an issue in the implementation of these initiatives. Activity theory attempts to bridge this gap of the research-practice dichotomy, and it opens the door to the “science of application that is sensitive to the complexity, interactivity, and unique elements of community and practice settings” (Livingood et. al, 2011, p.525). To apply activity theory, I analyze the historical example of the Rockefeller Foundation and why it has implications in intercultural health care implementation today. Then, I analyze the implications of intimate partner violence and how this relates to activity theory and maternal mortality rates.

The Rockefeller Foundation

Non-governmental organizations have played a role in intervening in healthcare in Latin America. In an example Ann Zulawski uses in her book, *Unequal Cures: Public Health and Political Change in Bolivia, 1900-1950*, the Rockefeller Foundation arrived in Latin America with their agendas and biases that played out in their intervention in health care. The Rockefeller Foundation formally worked in Bolivia as the Rockefeller

Foundation International Health Division which was started in 1913 with the goal of the "promotion of public sanitation and the spread of knowledge of scientific medicine", according to the Rockefeller Foundation International Health Division website. Less formally, it promoted "U.S. economic and political interests through the eradication of epidemic diseases and the development of U.S.-style medical institutions" (Zulawski, 2001, p86). The ideas of the Rockefeller Foundation were that "backwardness was mainly due to infectious disease that not only caused death but undermined productivity and life expectancy" (Cuento and Palmer, 2019). In other words, with a more Americanized health care system, the problems of Latin America could be solved.

Although they established that they would not initiate programs in "extremely impoverished ('backward') countries", Bolivia became a country of philanthropy because of their proximity to Brazil and the work the foundation was doing there (Zulawski, 2007, p.89). Even still, Bolivia never earned as much money or scholarship as other more developed Latin American countries like Mexico or Brazil even though it was, based on the foundation's assessments, the most in need of intervention. While working in Bolivia, the work of the foundation is riddled with racism that still has impacts on Bolivians and especially indigenous people's trust of outside help when it comes to healthcare. A doctor sent by the foundation, Dr. Robert Lambert, visited Bolivia in 1926 and "found little to praise about the medical school in La Paz, its personnel, or its curriculum" yet I argue that this opinion is based upon the foundation's agenda of imposing a U.S.-style medical institution (Zulawski, 2007, p.91). Even more, Dr. Lambert "was disturbed by the use of nuns in the hospital instead of professional nurses" yet "did mention, without comment, that of 125 medical students, four were women and that there were also four women

among the forty students of pharmacy" (Zulawski, 2007, p.92). His concern over the lack of educated women serving as nurses but not doctors or pharmacists reveals his own biases about these professions and the place of women. Only when we are looking through the Westernization lens do we often find nothing to praise about another country, and in this case, the foundation found exactly what they needed to confirm their already held present-day biases towards Bolivians and indigenous peoples.

In an example, a doctor from the foundation used extreme force on a woman to aid her which demonstrates the racism against the "Indians":

> "Dr. Walcott would tolerate no resistance and was determined to set an example for residents who might consider turning away the services representatives. In one case, Walcott, another doctor working for the service, and two inspectors forced their way into a woman's home. She responded by hitting Walcott with a club, slapping him in the face, and throwing a brick at him. Walcott in return hit her in the jaw, after which she acquiesced and allowed her water containers to be oiled." (Zulawski, 2007, p.96)

While the country was already receiving less aid than other Latin American countries, many of those most in need of help were discriminated against because their lives did not look like the lives of the Americans treating them. Could these experiences have influenced the present and correlate to a seemingly systematic disengagement of indigenous and rural people in health initiatives? Although in the 1940s the aims of the Rockefeller Foundation moved toward improving education rather than disease eradication, Bolivia gained little from this transformation because it was deemed "too poor to benefit" and "too backward scientifically to receive much support…that aimed to

develop the human resources and institutions to pursue basic science or modern agricultural techniques" (Zulawski, 2007, p.115).

While dissatisfaction with the Rockefeller Foundation grew as a result of growing nationalism, the racist ideologies against indigenous peoples remained among the Bolivian doctors who had for so long worked alongside the foundation (Zulawski, 2007, p.117). These beliefs have persevered and played a role in the present-day implementation of intercultural health care initiatives because these initiatives remain unable to gain the social capital of indigenous peoples is integral for mass utilization and thus the success of these initiatives. The history of the Rockefeller Foundation adds to the complexity of the problem of maternal mortality rates in Bolivia because the solution is not only about finding the medical solution but about finding the social solution that will aid implementation. This is activity theory; to understand the complexity of the past and present social factors means to understand the complications with implementation.

Intimate Partner Violence

Now, machismo and racism have persisted in present-day Bolivia. To add to our previous discussion of machismo, there is a correlation between intimate partner violence and healthcare outcomes for women. Intimate partner violence has gained serious attention recently as a threat to public health worldwide, and Bolivia is no exception (McCarraher, 2003, p.98). According to the National Statistics Institute of Bolivia, nearly half of femicides occur in indigenous communities (Flores, 2019). Femicide is the killing of a woman on account of her gender, and in Bolivia, in 2019, the femicide rate was 2.3 per 100,000 women (Davila, 2019, p.26). Not only is femicide and intimate partner

violence a serious problem in all of Bolivia, but it seems to affect different portions of the population.

In 2016, Bolivia was declared by *World Politics Review* as the most violent country in Latin America for women after ninety-three women were murdered by their partners or spouses while only a handful of those partners or spouses were prosecuted (Farthing, 2016, p.212). Canessa argues in *Intimate Indigeneities* (2012), that "indigenous peoples are greatly marginalized politically [which] may be a key feature of indigeneity" (Canessa, p.3). High instances of intimate partner violence and femicide, a factor of machismo, therefore can be linked to exclusion from the public sphere and histories of forced assimilation, a factor of racism. Their double discrimination is what puts them in this vulnerable position.

This shows how machismo manifests itself in indigenous communities because "gender-based violence is rooted in inequality" (Choup, 2016, p.452). This is not to say that indigenous men are more likely to be violent but that all of these social factors influence and are influenced by each other. Cunradi et al. (2000) in the study, *Neighborhood Poverty as a Predictor of Intimate Partner Violence Among White, Black, and Hispanic Couples in the United States: A Multilevel Analysis* finds that "characteristics of the social environment, such as neighborhood poverty, are associated with the risk of partner violence" (p.297). Poverty, inequality, racism, and machismo are some of these factors that are exacerbated by each other and exacerbate each other. Per activity theory, this is exactly why solutions are difficult to find and difficult to implement; there may not be one thing causing intimate partner violence nor maternal mortality rates.

Intimate partner violence is correlated to machismo because gender is determining the risk. I am bridging the gap in this study by bypassing intimate partner violence and finding the correlation between machismo and reproductive healthcare while maternal mortality rates function as a microcosm of reproductive healthcare as a whole for this study.

That being said, machismo manifests itself differently in Bolivia than in other parts of Latin America which makes it important to this study. For the sake of this study, machismo does not stand alone in Bolivia which is what makes it so unique. It is intermingled with high rates of racism with a high indigenous population as well as poverty. These social factors do not work separately but together, and they demonize indigenous people and practices. Besides, Bolivia is a unique case study for this thesis because of the high population of indigenous people. There is a sort of double discrimination for many women in Bolivia when they are also indigenous.

In one example, McCarraher found that there is a connection between intimate partner violence and various negative health outcomes (McCarraher, 2003, p.98). The study shows that forced sex is problematic for many Bolivians because women prefer the rhythm method as a contraceptive. The rhythm method requires collaboration from both sides but forced sex does not allow for this collaboration which can result in unwanted pregnancy, and women who reported having an unwanted pregnancy were three times more likely to experience intimate partner violence while pregnant (MacCarraher, 2003, p.98). As seen through McCarraher's study and others, while family planning has positive outcomes for women's health, many men both directly and indirectly oppose family planning efforts through the use of intimate partner violence and rape. This is just

one example of how intimate partner violence impacts the health outcomes for women in Bolivia, and this is not including indigeneity. Combining these facts about machismo as well as racism, we can see the double discrimination faced by indigenous Bolivian women.

Per activity theory, although it is already a complex health issue due to the time it takes, machismo and racism are two factors that contribute to making maternal mortality a complex health issue, therefore, requiring a complex solution. Poverty, intimate partner violence, historical racism, present day racism, and machismo all work together against indigenous women - against their health outcomes and against their abilities to access help in the form of intercultural health care services. Even more, as activity theory suggests, it takes more than a complex solution, but it also is complex in its implementation. Social capital theory begins to explain this complexity.

Social Capital Theory

For the sake of this study, social capital theory is relevant because it is a discussion about how community involvement and acceptance are important in garnering the usage of programs set in place by non-governmental and governmental organizations in combating the maternal mortality rate. One of the original proposers of social capital theory, Putman (1994), defined that "social capital refers to features of social organization, such as networks, norms, and trust, that facilitate coordination and cooperation for mutual benefit. Social capital enhances the benefits of investment in physical and human capital" (p.6-7). Social capital theory means that open conversation and community involvement define the individual decisions people make in their lives.

Simply put, if there is not cultural acceptance in using a program, it will not be effective because no one will use it.

Regarding reproductive healthcare, social capital theory means that open conversation and comfortability with sex and reproductive language are important to positive reproductive healthcare outcomes in general. In a study in Bolivia, Meyer (2014) finds a correlation between gender equality attitudes and sexual behavior, sexual experiences, and communication about sex among sexually active and non-sexually active adolescents in Bolivia and Ecuador (pp.1-8). The study finds that sexually active adolescents that value gender equality is more likely to report their most recent sexual experience as positive and consider it easier to talk about with their partner. It concludes that gender equality attitudes have a positive impact on adolescents' views of sexual experiences and reproductive health and wellbeing. Although this is not about maternal healthcare, it suggests that gender equality, arguably the opposite of machismo, plays a role in how women feel about their sexual experiences which then influences their willingness to talk about their sexual health and act upon it. In a *machista* society, men's opinions on sex, reproductive healthcare, and maternity influence how women view each of these topics and how they interact with their care concerning them.

Though many studies find that communication and agency are important factors in receiving positive healthcare outcomes and community engagement in healthcare programs, machismo limits open communication (Nelson et. al, 2014, p.189). Recipients of intercultural health care need to feel safe and be able to trust not just those that are providing the care but also those to whom they will go home. Social capital theory recognizes this. While not the case for all Bolivian women, if some do not feel like their

family, husband, or boyfriend will approve of something that they do to their bodies, they will not do it, or they could be forced if we refer back to our discussion on intimate partner violence. Because Bolivia experiences a high presence of machismo, this is a problem that women face in reproductive healthcare. Men and women have different attitudes towards sex and reproductive health in general (Paulson and Bailey, 2003, p.483). Poor communication is identified as a major constraint to improving reproductive healthcare. In a place like Bolivia where, due to machismo, women do not feel like they have a say in their healthcare outcomes, this is especially relevant.

Brandby's study, "Will I Return or Not? Migrant Women in Bolivia Negotiate Hospital Birth" (1999), examines agency through research on hospital birth experiences. The migrant women in this study, while they would go to the hospital to give birth, would only allow hospital workers to help after the birth, which is a more traditional ritual. This was a decision that was respected by the hospital. The study shows the effectiveness of the women being a part of the decision-making process rather than being "passive victims of technological birth" (Brandby, 1999, p.187). Leaving room for agency allows for a better transition to acceptance of modern medicine for two reasons. It makes the experience less intimidating if the woman has a say in what is allowed and what is not. Also, when a woman can still maintain some traditional practices within the healthcare setting, there is less community judgment for use of the healthcare services.

Ulin et. al (2006) interviewed women in the study "Investigación Aplicada en Salud Pública" about the myth in Bolivia that a woman cannot get pregnant while breastfeeding. Ulin et al. (2006) found that "la educación escolar se relacionaba directamente con el conocimiento correcto de la duración de la protección brindada por el

MAL (método de la amenorrea por lactancia)"[1] (p.64). Some of the answers are as follows:

> "'Bueno, si una está amamantando y no le vuelve el período y sigue amamantando al niño durante uno o dos años, está protegida durante ese tiempo.'
>
> 'Sí, he oído decir eso, pero también he visto que amigas que están amamantando quedan embarazadas.'
>
> 'Es mentira, porque yo quedé embarazada mientras daba de mamar a mi hijo.'
>
> 'No todas las mujeres tienen la misma constitución u ovulación [sic]. Algunas ovulan antes de la menstruación y hay otras que ovulan después de que vuelve la menstruación. En mi caso, óvulo antes. Las mujeres que ovulan antes y están amamantando se embarazan.'
>
> 'He oído que protege solo por seis meses.'"[2] (p.65)

The study asks why is this happening? Why is there such inconsistency in responses? The findings are that it is related to formal education. Therefore, false information is spreading in its own atmosphere. I argue that this is because the information is being shared through community networks as opposed to information being learning in a healthcare setting. Social capital theory provides insight into this

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[1] Translation: "School education was directly related with the correct knowledge of the duration of protection provided by MAL (Lactational Amenorrhea Method)"

[2] Translation: "Well, if you are breastfeeding you your period does not return and you continue to breastfeed the child for one or two years, you are protected during this time."
"Yes, I have heard of that, but I have also seen friends who are breastfeeding get pregnant."
"It's a lie because I got pregnant when I was breastfeeding my son."
"Not all women have the same constitution or ovulation. Some ovulate before menstruation and there are others that ovulate after menstruating. In my case, I ovulate before. The women that ovulate before and are breastfeeding get pregnant."
"I have heard that it protects for only six months."

study's questions. Once again, community opinions matter, and in Bolivia, racism, and machismo have kept Bolivians, especially indigenous Bolivians, from participating in intercultural health services. Therefore, their opinions, experiences, and decisions are based upon information outside of these intercultural health services even though they might be present. Even more, as we will address, the presence of a policy does not mean implementation of this policy. This explains the variation in answers to the myth about breastfeeding and pregnancy. Answers would consistently state disbelief in this due to science or hearing it from a doctor as opposed to some belief and maybe some disbelief because they have heard of an outlier to the myth. The responses to this survey go to show the importance of gaining social capital in implementing intercultural healthcare services. Moreover, the responses show that the social capital does not currently lie within the intercultural healthcare services implemented to decrease maternal mortality rates but outside of it, in the community. This is excluding the fact that educational attainment is not always chosen.

It only takes one husband or father distrusting a program to keep a whole family from accessing it. While efforts of outsiders may seem positive, histories of racism and machismo likely keep these efforts from being incredibly successful.

For example, while trying to do blood tests for yellow fever in Santa Cruz, many women refused due to the belief that "drawing blood had caused children's deaths a few days later" (Zulawski, 2007, p.97). The widespread participation of women and children in these tests was nearly impossible even when offered compensation (Zulawski, 2007, p.98). Despite efforts to intervene, there is a politics of blame in who is really at fault for a woman or her child's health going array. This example shows how community opinion

matters in garnering community and individual involvement in a healthcare setting. Although there are programs in place to combat maternal mortality rates in Bolivia, it will not be used if there is not discourse among men and women alike that support the program. Because of high instances of machismo in Bolivia, men's opinions on the bodies and medicine of women matter for women receiving adequate healthcare especially adequate reproductive healthcare.

Similarly, in Tapias' study, "Always Ready and Always Clean? Competing Discourses of Breast-Feeding, Infant Illness, and the Politics of Mother Blame in Bolivia" (2006), many women in rural Bolivia chose to cease breastfeeding despite efforts of the healthcare system to promote breastfeeding (Tapias, 2006, p.83). These women, due to folk discourse, believed that breastfeeding causes illnesses in their infants, so mothers who breastfeed and also had children that fell ill were made to believe it was their fault for breastfeeding. Per this study, readily available health choices may not be chosen due to community disapproval. Breastfeeding does not require any assistance or any sort of program to implement. Yet, women, like in this study, chose not to participate because of community disengagement.

In another example, Bender and McCann (2000) in their study discuss selected health behaviors of mothers (pp.1189-1196). In their study in Peri-Urban Bolivia, they find that the grandmother's education plays a role in selected maternal health behaviors such as prenatal care, breast-feeding, and family planning. Again, the opinion of other individuals in a mother's life can shape their pregnancy and health decisions because a grandmother's opinions and experiences shape a mother two generations later.

These examples highlight a systemic issue within Bolivia that can be explained by social capital theory which I apply to my research. For my research, I argue that machismo plays a role in keeping maternal mortality high in Bolivia despite efforts to combat it because similar to these examples, community opinions are keeping women from making their own decisions to utilize intercultural health care resources. If men have the social capital, they will influence decisions regarding their wife's or sister's or daughter's pregnancy and pregnancy-related care. The results of this can range from mother shaming in less serious cases and to intimate partner violence in more serious cases.

United Nations Population Fund Midwifery Program

The implications of this can be seen in modern-day efforts to decrease maternal mortality rates. Many indigenous women prefer birthing at home because they are treated as "second-class citizens, scorned because of their gender and traditions", but this has a high cost to the woman's health because traditional birth attendants have little education (Pelling, 2009, p.32). The United Nations Population Fund implemented a midwifery program in Bolivia in 2009 in an attempt to aid this problem. This model attempts to bridge the gap by providing a birthing method that provides more comfort to indigenous women than would a hospital. They estimate that they have met the needs of Bolivian women only by 29% through the availability of skilled birth attendants yet in 2019, they spent over $2 million in funding (UNFP, 2012). Here, the problem does not seem to be in funding but in implementation.

Their website suggests that they understand that this requires a complex solution because per their website, "the midwifery training program aims to improve care for

Bolivia's indigenous women by treating them with respect and dignity" (UNFP, n.d.). Also on their website, they have a section "bridging modern medicine and traditional medicine" (UNFP, n.d.). The goals of treating with respect and dignity and bridging modern medicine and traditional medicine are complex in their proposal, and the Midwifery program aims to address this complexity with skilled birth attendants. Nevertheless, the implementation of a skilled birth attendant is complex in its implementation. Underlying the words on their website is intercultural healthcare which, in theory, sounds like a step in the right direction. Yet, when policy and programs are aimed at certain health outcomes, it must be considered that there are choices in the usage of these systems. This is exactly what the discussion of social capital theory says when it comes to health care. Moreover, their website provides no information on location or the midwives or how they are accessed.

The program aims to train women in midwifery to increase skilled birth attendants present at birth. Per table 1, the United Nations Population Fund keeps count of birth attended by skilled health personnel. Midwives fit into this category. Their reported statistic of a 72% increase in births attended by a skilled professional seems promising, but per their website, there is no license to practice midwifery in Bolivia, and all that is required to train to be a midwife is high school education. Does this lead to questions of what makes skilled personnel skilled? Moreover, as with most Latin American countries, numbers reported for statistics are not always very reliable. Table 1 shows an account for this by showing a lower and upper estimate of the maternal mortality ratio by 100 deaths. Most likely, it is much higher than predicted due to lack of reporting.

Table 1: United Nations Population Fund Reporting on Midwifery Program

Maternal mortality ratio (deaths per 100,000 live births), 2017:	155
Births attended by skilled health personnel, 2014-2019:	72%
Range of MMR (maternal mortality ratio) uncertainty, lower estimate, 2017:	113
Range of MMR uncertainty, upper estimate, 2017:	213

Finally, when looking at the rural-urban divide, almost half of live births in 2012 in rural areas did not have a skilled birth attendant while almost all live births in urban areas did have a skilled birth attendant. Whether the data collection is unreliable or not, it seems clear that the rural-urban divide skews the results given by the UNFP especially when we consider that for this research, we are considering rural areas to be indigenous. Given this fact, indigenous women in Bolivia are still not receiving the care they should have based on the resources provided, and it indicates that the minimal progress made on diminishing maternal mortality rates in Bolivia since 2004 is very likely skewed by the rural-urban divide.

Also, their website reports randomly rather than every year. Moreover, there is little to no evidence, from my findings, of actual utilization of this program outside of the United Nations website. When intercultural healthcare programs are aimed at certain health outcomes, it must be considered that proposal and implementation are not the same things which are, what activity theory explains. Even more, social capital theory explains that implementation means nothing unless social capital is gained, and I conclude that

based on their lack of implementation and usage of their services in rural areas, they have failed to do so.

The Rockefeller Foundation is only one historical example of an outsider's attempt to increase access to healthcare in Bolivia, and the UNFP Midwifery program is only one example of current programs to combat the high maternal mortality rate in Bolivia. Yet, even though there are many programs in place to increase access to medicine and education like the Midwifery Program, these two examples serve as a template for all others that may have different approaches but do have similar effectiveness. There is still much disregard for these services and the perpetuation of information throughout communities because of past experiences with things like the Rockefeller Foundation that contributed to racism becoming integrated into the public healthcare system.

Governmental Organizations: Evo Morales

The election of Evo Morales in Bolivia is a historically relevant event for the country in many ways. Morales began his term in 2006 winning three elections for president comfortably even when the constitution states a two-term limit. In 2017, Bolivia's Plurinational Constitutional Tribunal ended term limits overriding the vote in 2016 in which 51.3% of Bolivians voted against changing the constitution to allow for Morales to run again (Farthing, 2018, p.212). Therefore, he ran again in 2019 for the fourth time, and while he received 45% of the vote, the results were met with protests as there was much reason to speculate about the electoral process. When Morales suggested holding a new election, the commander-in-chief of the Bolivian armed forces asked him to step down, and he obliged (Britannica).

To set the scene for the work of Morales, in 2002, the intercultural health program, EXTENSA, Programa Nacional para la Extensión de Cobertura de Seguros (National Program for the Expansion of Health Services), was put into place. Per Aizenberg's research, "Facilitating Indigenous Women's Community Participation in Healthcare: A Critical Review from the Social Capital Theory" (2014), EXTENSA is a program that was in place to expand health coverage for underserved populations through outreach activities and mobile health (p.91). The program had representatives of physicians and nurses "spend a few days in a given municipality" (Johnson, 2010, p.139). She argues that the success of a health campaign is due to tapping into social capital and fostering women's empowerment and how this applied to the facilitation of indigenous women's participation in their healthcare. By 2006, out of 339, "202 municipalities and 3,250 communities, covering 411,000 inhabitants", had been served by the representatives of EXTENSA (Pooley et al., 2008, p.211). Therefore, EXTENSA is somewhat successful in the sense that it is Bolivians who provided the resources as opposed to outsiders and that it emphasized education and active participation. Nevertheless, the resources provided by intercultural health programs like that of EXTENSA can be used to bolster collective community empowerment if utilized and be successful health campaigns, but the barrier to this empowerment is participation which is what social capital theory says.

Morales began his presidency in 2006, four years into EXTENSA. While serving as president, Morales set out to make a radical change concerning health, racism, and machismo because Morales was the first indigenous president of the country – these things had maybe not impacted him but at least his people. He began his process of

healthcare reform in 2006, but most significantly, in 2008, he implemented The Family Community Intercultural Health Policy (Salud Familiar Comunitaria Intercultural) which finds its grounding in the EXTENSA program (Berstein, 2017, pp.231-238). This policy attempts to address healthcare inequalities for indigenous people in Bolivia especially those living in rural areas by increasing primary care. As Bolivia has an indigenous population of well over 60%, implementing a policy aimed at this population played a large role in changing the state of Bolivia by attempting to incorporate indigenous practices into daily life (Bernstein, 2017, p.231). Simply, Morales institutionalized traditional medicine and reinterpreted primary healthcare and community participation models (Johnson, 2010, p.139).

Building on EXTENSA, the Family Community Intercultural Health Policy sent out mobile teams to rural areas with a physician, a nurse auxiliary, a dentist, a sociologist or a social worker, and a driver. The added sociologist or social workers is aimed to "'reorient' physicians and change attitudes within the medical establishment" as well as serve as an "(intercultural) broker between the medical personnel and the community, including any traditional medicine providers" (Johnson, 2010 p.139). The goals and the actions of this program seem to match because the stated purpose of intercultural healthcare and the use of a sociologist or social worker can promote this.

Another aspect of the Family Community Intercultural Health Policy was creating a specialized medical residency where medical students spend three years working under the supervision of a regional second-level hospital. Making this a part of the medical residency, it is students that are being sent there to learn as opposed to doctors being sent there to serve. I argue that this is not providing adequate resources to indigenous people

living in rural communities and makes recipients skeptical of the intercultural resources provided. When given the choice between a practiced traditional medical provider and a biomedical student, I predict that most indigenous Bolivians are choosing the former because it is familiar.

Overall, the policy "calls for the recognition of the strengths and limitations of both biomedicine and traditional medicine as part of an 'exchange of knowledge and practices between two medical cultures to articulation and complementarity between these actors, equally sharing the solution of problems and ensuring quality attention" (Johnson, 2010, p.147). Per a report provided by the Bolivian Ministerio de Salud y Deportes (Ministry of Health and Sports), the Family Community Intercultural Health Policy "se constituye en la nueva forma de sentir, pensar, comprender, y hacer la salud"[3] (Ministerio de Salud y Deportes, 2013). It seems that Morales attempted to reorient the way we think of Intercultural healthcare in Bolivia and was able to reflect this in policy, at least through words, which is promising for the future of intercultural health in Bolivia if future leaders continue building on this.

Despite the promise of the wording of the policy, while Morales set out to make radical social change for indigenous people and women, his promises mostly remain unfulfilled and the health of indigenous women seemingly has remained the same (DeJong, 2015, p.1). As shown previously, maternal mortality rates have only slightly gone down and not significant enough to attribute it to the policies of Morales. His policies put in place were inclusive and addressed many of the social problems in the country, but their implementation does not indicate widespread success. After a year of

[3] Translation: "becomes the new form of feeling, thinking, understanding, and doing health"

implementation, the majority of municipalities had yet to begin the implementation of the local teams. Here, the problem does not lay in the usage of the program but the implementation of it.

This problem of implementation is not limited to efforts to combat high maternal mortality rates. Heaton's research, "Has Morales Made a Difference?" (2014), examines Morales impacts on children's health and concluded that "inequality in access to doctors, child mortality, and child nutritional status did not diminish" because there are some aspects of health policy that are easier to implement (p.208). Concluded in this article, under Morales, inequalities in immunization decreased as opposed to malnutrition and high child mortality because immunization is more accessible to public policy than a more complex health problem (Heaton et. al, 2014, p.208). Comparing to immunization, diminishing maternal mortality rates takes much more than increasing the number of vaccines available in clinics in more rural areas. Unlike vaccines, while maternal health services may be available, they may not be used for a variety of reasons, and it is nearly impossible to implement one policy that is going to change this. Also, it is more than just one or two shots like that of immunization. This explanation of the complexity of the problem requiring a more complex solution is what activity theory suggests.

Even internally, efforts to decrease the maternal mortality rates in Bolivia have little success. As stated previously, histories of racism and machismo, through systemic underfunding of women's healthcare, not listening to women, etc., play a role in this, but evidenced by this section, maternal mortality is an extremely complex health issue. It takes addressing all aspects of women's and families' lives whether it is combating racism and machismo or increasing access to healthy food, education, and maternity

leave. Per activity theory, maternal mortality rates are a complex issue because it is so intimately tied to where we live, work, and play. It is not only about implementing maternal health services but so much more which takes time and money. Therefore, Morales' efforts are not misguided but only overly optimistic.

Discussion

In general, healthcare has historically been an issue in which organizations and governments have attempted to intervene in the developing world. Diminishing maternal mortality rates has been one of the many areas of focus. Nyamtema et. al published in "Maternal Health Interventions in Resource-Limited Countries: A Systematic Review of Packages, Impacts, and Factors to Change" (2011), that there are yearly 360,000 maternal deaths, 4 million stillbirths, and 3 million early neonatal deaths were related to complications of pregnancy which is far higher than deaths due to HIV/AIDS, tuberculosis, and malaria combined (p.1). Nyamtema et. al wrote that globally, despite efforts in the last 20 years to increase public health access in resource-limited countries, access to public health remains an issue in these countries, and they found that "no single magic bullet intervention exists for reduction of maternal mortality" (Nyamtema et. al, 2011, p.8). Globally, there has not been a sufficient solution proposed for reducing maternal mortality rates, and Bolivia is not exempt from this.

Nyamtema et. al (2011) does conclude, though, that lack of quality leadership in the public sector is more of an indicator of poor performance in the public sector than lack of national resources (p.9). For example, in 2018, there were 17 maternal deaths per every 100,000 live births in the United States as compared to 3 maternal deaths per every 100,000 live births in other high-income countries like the Netherlands, Norway, and

New Zealand (Tanne, 2020, p.45). Even more, the United States is considered an anomaly when it comes to maternal mortality rates as its rates are high for a developed country, and as this study suggests, it is because of a lack of quality leadership in healthcare in the United States. This applies to Bolivia because as this section discusses, the leadership of Evo Morales in Bolivia is troubled. Therefore, this study's recommendation for going forward in intervention efforts against maternal mortality was:

> "mobilizing political will and commitment, leadership development strategies, establishment of performance management and appraisal systems to enhance creativity and innovations in the domain of reproductive health, strengthen community participation, integrating non-governmental organizations into motherhood programs, sharing information within and among countries and empowering women with education, autonomy, and economy." (Nyamtema et. al, 2011, p.9)

This very recommendation is what social capital theory suggests – that community and women's empowerment through education and intercultural healthcare will be the solution. Yet, this does not seem to be the solution pursued by organizations in Bolivia. Moreover, as activity theory suggests, solutions to complex problems are complex in their implementation for the very reasons that the issue itself is complex. Racism and machismo worsen maternal mortality rates, and racism and machismo make the implementation of intercultural healthcare services difficult.

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III. Quantitative Analysis

Machismo Study

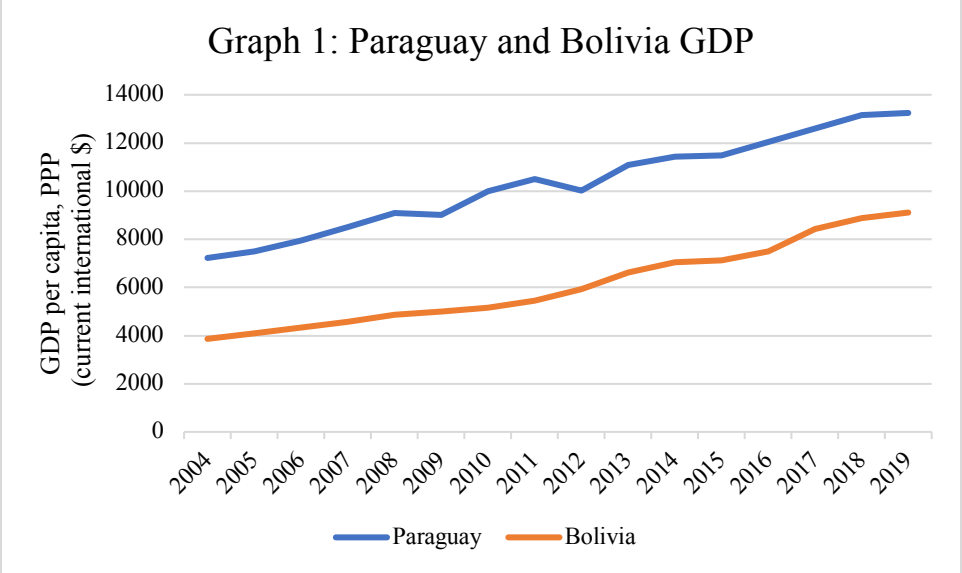
The use of quantitative research shows the correlation between data while qualitative research explains this relationship. This quantitative study aims to find the correlation between Bolivia and Paraguay to justify the differences in machismo in Bolivia compared to machismo in Latin America. I look specifically at Paraguay because it is another poor Latin American country.

I am comparing Bolivia and Paraguay to exemplify that machismo is a relevant social factor in Bolivia that makes the reasoning behind its maternal mortality rates different from other countries Latin American countries. I use world development indicators on the World Bank database to show the similarities between the two countries. I have chosen to use GDP per capita, PPP (current international dollars) from 2004 to 2019 provided by the World Bank database, and the Gini Index per the World Bank estimate to compare the two countries. Looking at GDP per capita accounts for the population difference between the two countries because Paraguay has a population of 7.045 million while Bolivia's population is 11.51 million, as reported by the World bank in 2019. The Gini index accounts for wealth dispersion and wealth inequality within a country. These indicators are representatives of poverty and socioeconomic levels within the country.

Analysis

This study shows that although Bolivia and Paraguay are similar in that they are both developing Latin American countries, their maternal mortality rates do not match. This reveals that factors are contributing to this issue in Bolivia that are not of the same relevance in Paraguay. I argue that one of the factors that have a strong influence on this difference is machismo.

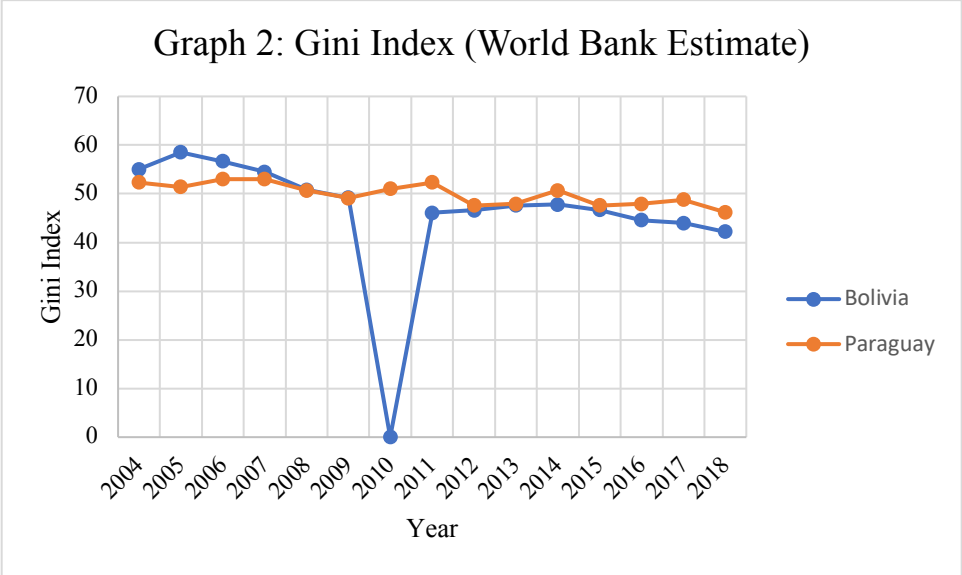
This study looks at the years between 2004 and 2019, and per graph 1, the GDP per capita in current international dollars compared between Bolivia and Paraguay has maintained similarities from 2004 to 2019. The line above represents Paraguay while the line below represents Bolivia. As you can read from the graph, although the GDP is not the same, the rate at which the two changes follow a similar slope.



For further comparison, per graph 2, although there is missing data between 2009 and 2011 for Bolivia, for the years 2004 to 2018, Bolivia and Paraguay share a similar Gini index. They switch places from 2004 to 2009 and 2011 to 2018 with Bolivia being

represented as higher in the former. This shows that their wealth dispersion is similar in these years.

The combination of the study of current GDP in US dollars and the Gini Index shows that Bolivia and Paraguay are relevant to use for comparison especially when we consider their other similarities - a similar history of colonialism, location, etc. Therefore, the similarity of the socioeconomic level of the two countries makes the comparison of their maternal mortality rates relevant.



Now, I am comparing their maternal mortality rate and ratio provided by the World Bank database and UNICEF, and this comparison is to show how machismo manifests in Bolivia more strongly. As I have argued, machismo is a unicausal factor influencing maternal mortality in Bolivia, so Paraguay's diminished maternal mortality rate in comparison must not share these factors. Therefore, machismo is a contributing factor to this complex health problem more so than it does in Paraguay.

The statistics provided by the World Bank database compare the maternal mortality ratio of the two countries. Table 2 shows the maternal mortality ratio and

maternal mortality deaths from UNICEF. Table 3 cites Bolivia's maternal mortality rate as 850 in 2000 and 380 in 2017. Based on the comparison of these two, Bolivia's maternal mortality rate is significantly higher than that of Paraguay.

Table 2: Paraguay's Maternal Mortality, per UNICEF

Year	Maternal Mortality Ratio per 100,000 live births	Maternal Deaths
2000	162 (131-206)	230
2005	136 (111-168)	190
2010	107 (91-127)	150
2015	89 (77-101)	130
2017	84 (72-97)	120

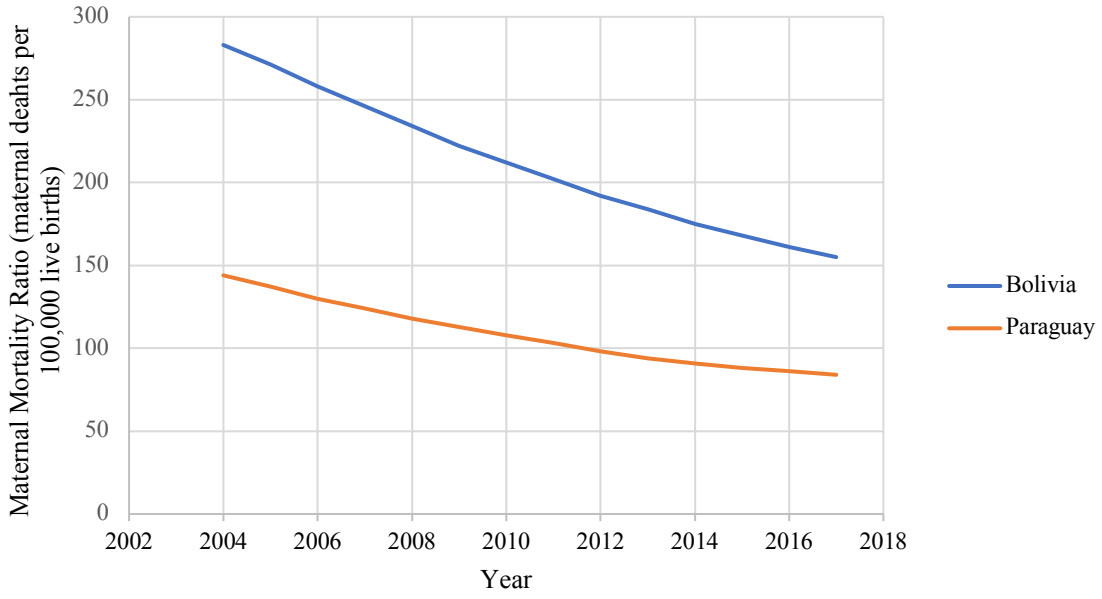
Table 3: Bolivia's Maternal Mortality, Per UNICEF

Year	Maternal Mortality Ratio per 100,000 live births	Maternal Deaths
2000	331 (272-405)	850
2005	271 (221-332)	690
2010	212 (168-267)	530
2015	168 (125-223)	420
2017	155 (113-213)	380

Graph 3 visualizes the comparison of the maternal mortality rates of the two countries. While displaying a similar slope, Bolivia is consistently higher than Paraguay

by at least 100 more maternal deaths per 100,000 per year. About the previous study, their Gini Index is similar, and the GDP in Paraguay is higher but changes at a rate consistent with Bolivia's GDP. The similarity of these two factors might make one assume that their maternal mortality rates would be similar or at least change at a constant rate. Yet, this is not the case. Bolivia's maternal mortality rate is significantly higher.

Graph 3: Maternal Mortality Ratio of Paraguay and Bolivia



By comparing the two countries, I argue that the maternal mortality rate is correlated with machismo which has stronger implications in Bolivia than in Paraguay. This seems to make sense because Bolivia's and Paraguay's maternal mortality rates are vastly different despite their similarities. Therefore, I conclude that there is something else at play in Bolivia than history, location, or socioeconomic factors that are not impacting other Latin American countries the same way, as exemplified through Paraguay. This leads to the next quantitative study.

Correlation Study

I use quantitative research to answer my research question of how machismo plays a role in maintaining a high maternal mortality rate in Bolivia. I am using statistics from the World Health Organization, UNICEF, and the World Bank. All three of these sources provide statistics on maternal mortality, and I will use each of these in comparison to gain an understanding of gaps and variation in data because data reporting in Latin American generally and Bolivia more specifically is limited. I look at statistics from 2004 to 2019.

The World Bank database has 624 indicators for gender statistics. This is what I am using to measure machismo because the gender statistics are manifestations of machismo in the law, the economy, and everyday life. I began by eliminating any indicator without at least half of the statistics available for the years in my timeline which got rid of a handful of the 624 indicators. After eliminating any gender statistic missing more than three years of available data, 245 indicators were left. Then, I eliminated any for which there are yes/no (1/0) answers, the indicators are down to 150. Finally, I only used the ones with all available years which brought the final number of gender statistics to use to 40. The breakdown of these numbers shows how the lack of available data can limit research in Bolivia. With so many gaps in data, 624 indicators that should be available on the World Bank database becomes only 40. These include labor force participation, employment ratio, contributing family members ratio, school enrollment, vulnerable employment, and rate of out-of-school youth. Finally, I found the correlation coefficient of these 40 gender statistics.

Analysis

Table 4 shows the results of the correlation test. Of the 40 correlation coefficients found, twelve of them have a value of $1.00 > x > 0.90$ or $-1.00 < x < -0.90$ because these are the results with the strongest relationship to maternal mortality rates. They are rounded to three significant figures. The table includes these twelve results. Interestingly, though, only five of the forty have a value of $-0.50 < x < 0.5$ meaning that even of the values that I excluded, there seems to be still a significant relationship between the given gender statistic and maternal mortality rates.

Eleven of the twelve have a positive correlation. They are the percentage of female contributing family workers, percent of male contributing family workers, female infant mortality rate per 1,000 live births, male infant mortality rate per 1,000 live births, the under-five female mortality rate per 1,000 live births, the under-five male mortality rate per 1,000 live births, female number of infant deaths, male number of infant deaths, male primary school enrollment, female primary school enrollment, and male wage and salaried workers. First, the correlation with infant mortality rates is to be expected because when health is compromised in one area (maternal health), it is not all that unlikely that it would correlate to other health outcomes. The other are male/female contributing family workers, female primary school enrollment, and male wage and salaried workers. As maternal mortality rates go up so do these statistics.

Table 4: Correlation of Gender Statistics and Maternal Mortality Rate

Gender Statistic	Correlation Coefficient
Contributing family workers, female (% of female employment) (modeled ILO estimate)	0.906
Contributing family workers, male (% of male employment) (modeled ILO estimate)	0.968
Labor force, female	-0.905
Mortality rate, infant, female (per 1,000 live births)	0.999
Mortality rate, infant, male (per 1,000 live births)	0.999
Mortality rate, under-5, female (per 1,000 live births)	0.999
Mortality rate, under-5, male (per 1,000 live births)	0.999
Number of infant deaths, female	0.999
Number of infant deaths, male	0.999
School enrollment, primary, female (% gross)	0.968
School enrollment, primary, male (% gross)	0.970
Wage and salaried workers, male (% of male employment) (modeled ILO estimate)	0.904

According to the database, “contributing family workers are those workers who hold ‘self-employment jobs’ as own-account workers in a market-oriented establishment operated by a related person living in the same household” and “wage and salaried workers (employees) are those workers who hold the type of jobs defined as ‘paid

employment jobs,' where the incumbents hold explicit (written or oral) or implicit employment contracts that give them a basic remuneration that is not directly dependent upon the revenue of the unit for which they work". While the correlation coefficient for waged labor is for males, combined with the correlation coefficients of contributing family workers, this could suggest that no matter the type of work, increased labor of both members of the household is correlated to maternal mortality rates.

"Gross enrollment ratio is the ratio of total enrollment, regardless of age, to the population of the age group that officially corresponds to the level of education shown. Primary education provides children with basic reading, writing, and mathematics skills along with an elementary understanding of such subjects as history, geography, natural science, social science, art, and music", according to the World Bank database. It seems opposite of that which one would expect that an increase in education is correlated to an increase in maternal mortality rates. I hypothesize that this is due to another outside factor correlated to each, but that is for another study.

One of the twelve with a negative correlation is the female labor force, and it is the female labor force. This means that as the maternal mortality rate goes up, the female labor force has gone down. According to the database, "female labor force comprises women ages 15 and older who supply labor for the production of goods and services during a specified period. It includes people who are currently employed and people who are unemployed but seeking work as well as first-time job-seekers. Not everyone who works is included, however. Unpaid workers, family workers, and students are often omitted, and some countries do not count members of the armed forces. Labor force size tends to vary during the year as seasonal workers enter and leave." This might suggest

that it may be a beneficial thing that fewer women are in supply labor whether they are receiving higher education or employed elsewhere. Nonetheless, for each of these conclusions, correlation need not mean causation.

Overall, the 40 results are focused on childhood mortality rates, education, and labor force which means that these three things are correlated to maternal mortality rates or at least, health outcomes for individuals. Despite this, the conclusions of the quantitative research are marginally helpful in determining that machismo is a relevant factor in maternal mortality rates. The lack of available data limits the quantitative study because I had to use the gender statistics available as opposed to hand-picking those best suited to measure machismo. Some of the excluded factors that would have been helpful include: decision-maker about a woman's own health care, educational attainment, female professionals, length of paid maternity leave, the proportion of women in ministerial positions, women who believe a husband is justified in beating his wife, and women who believe is wife is justified in refusing sex to her husband. Even more, correlation only describes a relationship but does not explain it. For this reason, the qualitative research of this paper is more helpful than quantitative research in answering my research question.

IV. Conclusion

The maternal mortality rate in Bolivia remains one of the highest in Latin America (Pelling, 2009, p.32). In 2017, according to the World Bank database, there were 155 maternal deaths per every 100,000 live births. While there are efforts in place by non-governmental organizations and governmental organizations to combat the high maternal mortality rate like the United Nations Population Fund's Midwifery Program and the Family Community Intercultural Health Policy, the analysis of the rate of maternal mortality from 2004 to 2019 shows little change in the rate that can be attributed to these intercultural healthcare initiatives. So, Bolivia's maternal mortality rate remains extremely high despite these efforts. I argue that Bolivia's maternal mortality rate remains high despite efforts to combat it because of the prevalence of machismo and racism in the daily lives of Bolivians and especially for indigenous peoples in Bolivia who make up more than 60% of the population (Berntsein, 2007, p.231).

In Bolivia, being indigenous and a female puts one at a disadvantage in all sorts of the term. Through the social capital theory and activity theory framework, I conclude that the failure of Bolivia's intercultural health services when it comes to combating maternal mortality rates is due to the persistence of machismo and racism. The application of activity theory reveals that maternal mortality is a complex health issue that will require a complex solution and implementation. It is complex because it is influenced by a multitude of factors even though I only analyzed machismo and racism for the sake of this research. While policy and intercultural healthcare services are beginning to trend

towards finding these complex solutions, they are also complex in their implementation because of the very factors that cause it - machismo and racism. Social capital theory explains the complexity of implementation.

While social capital theory shows how community engagement is essential in garnering participation in programs already set up to combat the high maternal mortality rate, the maternal mortality rate remains high because machismo and racism are the most powerful actors in social capital keeping intercultural health services from gaining popularity in rural, indigenous communities. People's opinions matter, and Bolivians, especially indigenous Bolivians, opinions shaped by machismo and racism are what has kept their maternal mortality rate high over the years despite efforts to decrease it.

Moreover, machismo is what keeps Bolivia's maternal mortality rate high as compared to other Latin American countries because machismo in Bolivia manifests itself uniquely. I compare Bolivia and Paraguay and conclude that despite their surface-level similarities, Bolivia's maternal mortality rate is much higher, and this is due to machismo's significant presence in indigenous communities in Bolivia. Even more, Bolivia's indigenous population (60%) is much higher than its Paraguayan neighbor's (2%) (Berstein, 2017, p.231, IWGIA, n.d.). This magnitude of indigenous people contributes significantly to the shortages of intercultural healthcare services because its size makes it that much more significant in Bolivia than in Paraguay.

Finally, the intercultural healthcare services' in place inability to combat maternal mortality in Bolivia is due to the inability of these services to capture the social capital of indigenous communities. The slight diminishing of maternal mortality rates is skewed because although it may be improving in urban areas, it is not in rural communities thus

showing that these intercultural services are not working. I argue that machismo and racism are what keeps the social capital from these services. Moreover, these services need to address the complexity of the issue. Social factors are important everywhere in determining healthcare. We are much more affected by where we live, work, and play than by where we go to see a doctor. Therefore, increasing only the usage of a skilled birth attendant at the moment of birth is not going to significantly decrease maternal mortality rates. Efforts need to be made to increase the overall health and use of intercultural healthcare services in all aspects of rural life to aid in the diminishing of Bolivia's maternal mortality rates.

Limitations

While some of this research is based on statistics, it is necessary to mention the problematic use of statistics in Latin America and especially Bolivia. For example, in my quantitative research, the second part about the correlation between maternal mortality and gender statistics is extremely limited on the lack of adequate information provided. Moreover, I did not use statistics provided by Bolivia because they tend to be inaccurate and/or politicized especially those for health. After all, Morales' agenda was to promote healthcare. This research and much research in Bolivia is incredibly limited by lack of accurate statistics, but this can aid in my discussion about inadequate services because until there are adequate statistics to translate into an adequate understanding of the severity of the problem, we cannot fully embrace efforts to diminish it.

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